State of Arizona

Board of Homeopathic and Integrated Medicine Examiners

1740 W. Adams, Ste 3017 Phoenix, AZ 85007
Telephone (602) 542-8154
www.homeopath.az.gov
info@homeopath.az.gov

APPLICATION FOR LICENSE AS A HOMEOPATHIC PRACTITIONER

1. **Name** ____
(As you wish it to appear on your license)
Clinic Address ____

City ______________________________ **State**_____ **Zip code** __________________

Home Address____

City ______________________________ **State**______ **Zip code**_______________

Daytime telephone ____________________________**FAX**____________________________

Email address:____

2. **<u>Your application is not complete until the Board office has received all verification documents.</u>**

Applicants must contact the organizations or individuals to have verification sent directly to the Board. Records and documents must have an original (not photocopied) signature, stamp or seal of the official authorized to maintain the records of the organization or individuals.

Any documents that are not in English must be accompanied by an acceptable, original translation, performed by a qualified translator, which includes all written and printed material on the original. An Affidavit of Accuracy in which the translator who performed or verified the translation affirms that the entire document has been translated, that nothing has been omitted or added, and that the translation is true and correct, must accompany the translation.

3. Examination:

______ I will take the State written examination.
(The application fee is applicable for one year from the date filed)

______ I have taken and passed a CHC Examination
(The application fee is applicable for one year from the date filed)

______ pursuant to the Americans with Disabilities Act (ADA) I request a reasonable accommodation be made for the examinations. I have attached, on a separate piece of paper, an explanation of the accommodation requested.

4. _____ I enclose the application fee of $250 (U.S. funds) payable to the ***Board of Homeopathic and Integrated Medicine Examiners*** and understand that this fee is not refundable. Upon approval you must submit an additional $150.00 License issuance Fee.

EDUCATION

Attach documentation to

5. I have successfully completed:

One of the following:

____ A program that would qualify an applicant to become certified or licensed to practice pursuant to chapter 8, 14, 19 or 39 of title 32.

____ Training and testing by the United States armed forces at a level comparable to the national standards for emergency medical care technicians.

____ A program that is approved or accredited by the accreditation commission for homeopathic education in North America, or its successor organization, or any similar board-approved body that accredits this course of study.

Attach proof of program completion.

Name of qualifying program:
____

Degree or certification received:
____

Address for qualifying program:
____

AND

One of the following:

____ Hold, or pass the examination to hold, a certification from the council for homeopathic certification or its successor as designated by the board.

____ Complete a program that is approved by the board and that is designed to prepare the person for the practice of homeopathic medicine.

Attach proof of examination or program completion.

6. List below the accredited training program from which you received your homeopathic education and have the school submit written verification of your graduation to the Board.

____

Name of school **year of graduation**

7. Do you have a doctoral degree and request to use the designation Doctor of Homeopathy?

____

Name of school and degree title

Attach proof of completion of Doctoral Program

8. List all states/ jurisdictions (including Canadian provinces and foreign countries) in which you are or ever have been licensed to practice medicine. Attach additional sheets if necessary. Have each state/jurisdiction submit written verification of the status of your license there to the Board.

____

____

____

BACKGROUND

Please answer "yes" or "no" to each question.

________ 9. Within the past ten years, have any medical malpractice suits been filed against you, including claims for which no corresponding lawsuit was filed?

________10a. Have you ever been convicted of, or pled guilty or *nolo contendere* to any criminal charges requiring adjudication in an adult court of record?

________10b. Have you been charged with any crimes that are pending adjudication in an adult court of record?

________11. Has any state or jurisdiction ever refused or denied you a license to practice medicine, or allowed you to withdraw your application during the consideration of such action?

________12. Has any state or jurisdiction ever placed your license to practice medicine on probation, ever suspended, limited or restricted your license or revoked your license, or accepted the surrender of your license during the consideration of such action?

________13. Has any state or jurisdiction (including federal agencies) ever suspended, limited, restricted, revoked, denied or accepted surrender of your privilege to possess, dispense or prescribe controlled substances?

________14. Within the past ten years, have you had any mental illness or psychological condition that impaired your ability to practice medicine or function as a student of medicine?

________15. Are you now, or have you been within the past ten years, dependent upon alcohol or drugs?

________16. Has any specialty practice board or college ever suspended, revoked or denied re-certification of your standing with that board or college?

________17. In compliance with the Personal Responsibility/Work Opportunity Reconciliation Act (PRWORA) regarding State and local benefits (professional licenses are defined as a benefit) please mark whether you are a citizen of the United States. Yes ( ) No ( ).

If you are not a citizen of the United States, do you hold qualified alien status? Yes ( ) No ( )
(Please attach a copy of a document that evidences your status as either a citizen of the U.S. or a qualified alien. A list of acceptable documents is attached)

IF YOU ANSWERED "YES" TO ANY QUESTION (12-19) ABOVE, ON A SEPARATE SHEET OF PAPER PROVIDE DETAILS DESCRIBING THE INCIDENT, THE DATE AND LOCATION OF THE INCIDENT. IDENTIFY THE AGENCY, COURT OR ORGANIZATION INVOLVED AND ANY ACTION TAKEN.

Pursuant to A.R.S. § 32-2933(27), attach any informed consent material patients will sign for other diagnostic or therapeutic procedures used in your practice, including but not limited to: electro-diagnosis or therapy apparatus, other non-traditional therapy apparatus, homeopathic treatments or substances in use less than ten years.

Pursuant to ARS §32-2933 (41) it is an act of unprofessional conduct for failure to obtain a **signed informed consent** from a patient prior to beginning examination or treatment. **This informed consent shall include language which makes it clear that the Practitioner is providing homeopathic medical treatment instead of or in addition to standard conventional allopathic treatment.**

IDENTIFICATION

18. Date of birth________________________
19. Place of birth________________________
20. Gender________________________
21. Height________________________
22. Weight________________________
23. Eye color________________________
24. Hair color________________________
25. Identifying marks ________________________
26. SSN ________________________

OVER THESE WORDS, ATTACH TWO PICTURES OF YOUR FACE TAKEN WITHIN THE PAST 60 DAYS. DOUBLE PRINT PASSPORT PHOTOS ARE ACCEPTABLE.

SIGNATURE AND ATTESTATION OF APPLICANT

27. I, ______________________________, am the applicant and hereby attest that all answers given above and all documentation I have provided or caused to be provided in support of this application are complete, true and correct. I further attest that I have provided to the Board of Homeopathic and Integrated Medicine Examiners any additional information, even that not explicitly requested, which bears on my competency to practice medicine, or on my ability and willingness to practice in a professional manner. I understand that providing false, deceptive or incomplete information to the Board may result in the denial of my application for licensure or charges of unprofessional conduct. I further agree

that, in consideration of the issuance of a license to practice medicine as a homeopathic Practitioner in the State of Arizona, I will abstain from unethical and deceptive advertising, from unethical and immoral conduct and practice, from charging excessive fees and from association with firms or individuals who exploit the public for monetary gain by employment of Homeopathic Practitioners.

Signature of applicant Date

A.R.S.41-1030(B) An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule, or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.

A.R.S. 41-1030(D) This section may be enforced in a private civil action and relief may be awarded against the State. The Court may aware reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the State for a violation of this section.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize individuals, organizations, previous employers, and schools to provide any information they may have regarding me, whether or not it is in their official records. This may include otherwise privileged or confidential information relative to my professional qualifications, credentials, clinical or professional competence, character, mental or moral behavior, or any matter that bears on consideration of a license to practice, permit or registration offered by or through the ***Arizona Board of Homeopathic and Integrated Medicine Examiners,*** 1400 West Washington, Room 230, Phoenix, Arizona 85007. Telephone (602)-542-8154, FAX: (602)-542-3093.

I, the undersigned, release all individuals, organizations, previous employers, and schools from all liability for any damages that may result from issuing this information.

Further, I extend to the ***Arizona Board of Homeopathic and Integrated Medicine Examiners,*** its authorized representatives, and any third parties absolute immunity and release from liability for information gathered from public records and/or interviews as outlined above.

I, the undersigned, agree that a photocopy of this authorization is to be accepted with the same authority as the original, and I specifically waive written notice from any present or former employer and/or organization that may provide information based upon this authorized request.

____
Name (please print)

____
Street Address

____
City, State and Zip Code

____
Date of Birth

____
Maiden, former name or aliases (please print)

____
Signature Date